

**NURSE BURNOUT IN A HIGH STRESS HEALTH CARE ENVIRONMENT:  
PROGNOSIS BETTER THAN EXPECTED?**

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This article presents literature-based evidence from North America, Canada, Israel, England and Wales, New Zealand, Australia demonstrating that despite data showing that occupational stress levels are rising in nursing, and given that nursing is an endemically stressful profession, there does not seem to be a widespread concomitant increase in reported severity of burnout. Instead, many instances of low, decreasing and in some cases, virtually nonexistent degrees of burnout exist. Two theoretical explanations for the existence of low burnout and the implications for the nursing profession are discussed.

**Keywords: nurses, burnout, MBI, job stress, health care environment, empowerment.**

## **Introduction**

In the mid to late 1990s, economic constraints led to radical changes in health care systems in most developed countries. Organisational policies for retrenchment in hospitals included such strategies as downsizing, restructuring, and re-engineering. Health care restructuring has led to the elimination of available hospital beds, merging of units, departments and programmes, and consolidation or closure of hospitals (Aiken, Clarke, & Sloane, 2002b). Human service workers have been laid off or relocated and the nature of work for many employees has been significantly altered. Nursing personnel are the largest group of health care workers employed by hospitals. As a result of ongoing change, nurses face challenges requiring them to provide high-quality care at lower costs and the impact of this on nurses has been considerable and far-reaching. With less staff to care for patients, the workload for nurses has significantly increased. Overall, stress levels increase when more patients have to be processed in the same number of hours and turnover is faster than in the past (AbuAlRub, 2004; Aiken, Clarke, Sloane, Sochalski, & Silber, 2002a).

### **1. The apparent paradox - a low degree of burnout in a high stress health care environment**

It is generally speculated that the enormous pressure of practicing in a stressful and constantly changing health care environment may increase the prevalence of job burnout among nurses (Ledgister, 2003a). Burnout is a problem because it is associated with lower morale, reduced job performance, increased tardiness, job turnover, loss of productivity, high rates of absenteeism, and poor physical, mental and emotional health for individual workers (Hillhouse & Adler, 1997; Wright & Bonnett, 1997). Many studies recently however have discovered low degrees of burnout among nurses as an occupational group. Burnout is

measured by the Maslach Burnout Inventory (MBI) (Maslach, 1982; Maslach & Jackson, 1986). The 22 -item version MBI is a three component conceptualisation of burnout; comprising of seven measures for feelings of emotional exhaustion [EE] (having no capacity left to offer psychological support to others), eight measures of a tendency to depersonalize others [DP] (having a negative or callous attitude toward colleagues or patients), and eight measures of diminished feelings of personal accomplishment in working with others [PA] (playing down or disregarding positive job performances and past achievements).

Respondents are instructed to answer each time according to the degree to which each MBI statement was like or unlike their reactions to work. The scale used is 1 = very unlike me, through to 7 = very much like me. The MBI provides three scores that represent the sum of scores of the individual items pertaining to each of the three separate subscales. Results are reported in terms of a high, moderate and low degree of burnout depending on the respective scores for each measure. A *high degree of burnout* is reflected in high scores on the EE and DP subscales and in low scores on the PA subscale which is rated inversely. An *average degree of burnout* is reflected in average scores on the three subscales, and a low degree of burnout is reflected in low scores on the EE and DP subscales and a high score on the PA subscales (Maslach et al., 1986). A *low degree of burnout* (low burnout) therefore represents a positive psychological condition rather than the stereotypical negative condition that is widely associated with the burnout syndrome.

Findings of low degrees of burnout, i.e., low scores on the EE and DP and a high score on the PA MBI subscales, are reported in the following studies among nursing populations in England and Wales (Carson, Fagin, Brown, Leary, & Bartlett, 1997; Carson, Leary, de Villiers, Fagin, & Radmall, 1995; Carson, Wood, White, & Thomas, 1997; Carson et al., 1999; Coffey & Coleman, 2001; Edwards, Burnard, Coyle, Fothergill, & Hannigan, 2000;

Hannigan, Edwards, Coyle, Fothergill, & Burnard, 2000; Malassiotis & Haberman, 1996; Prosser et al., 1996; Whittington, 2002), North America (Lee & Henderson, 1996), Canada (Hall, Thorpe, Barsky, & Boudreau, 1999), Israel (Malach-Pines, 1999a, 1999b, 2000, 2002, 2004), Australia (Allen & Mellor, 2002), New Zealand (Hall et al., 1999; Hall, 2001), and Europe (Buunk, Ybema, Gibbons, & Ipenburg, 2001a; Demerouti, Bakker, Nachreiner, & Schaufeli, 2000, 2001). Research discovering low burnout among nurses is unexpected because of the widely held perception that nursing is one of the most inherently stressful and burnout prone occupations. For example Farrington (1995:474) states that the nursing culture in the 1990's typically encapsulates the notions of stress and burnout for being synonymous with the rigours of nursing". This recent (1996 onwards) apparent trend of empirical research finding lower than anticipated levels of burnout among nurses is summarised by (Butterworth, Carson, Jeacock, White, & Clements, 1999:32) who note that:

A[O]ur data show that occupational stress levels are rising in nursing over recent years. Despite this, there does not seem to be a concomitant increase in levels of psychological distress or in occupational burnout.@

These findings are also puzzling in light of continuing reports of high stress (Semmens, 2000), increasing pressures in healthcare (Zellars, Hochwater, & Perrewe, 2000), problems of retaining existing Registered Nurses (Ledgister, 2003a, 2003b), a high incidence of nurses= job dissatisfaction (Aiken et al., 2002a), and forecasts of future nurse shortages (Keidel, 2002).

This article reviews the literature on nurse stress and burnout in order to address the question of why burnout might be lower than expected in a high stress occupation. Two theoretical reasons accounting for low burnout in nurses as a specific population are described and the

implications of this knowledge for the nursing profession are discussed.

## **2. Nurses= job stress**

Job related stress is a widespread problem across industry, but it is endemic in the human services where nurses form the largest group (Cherniss, 1980; Schaufeli & Greenglass, 2001). The topic of job stress in nursing has been documented for more than forty years (Edelwich & Brodsky, 1980; Marshall, 1980; Menzies, 1960) and occupational stress in nursing is reported to be increasing in many countries. These countries include North America (Aiken et al., 2002a; Chen & McMurray, 2001; Mee & Robinson, 2003), Canada (Burke & Greenglass, 2001; Garrett & McDaniel, 2001; Jamal & Baba, 2000), England and Wales (Butterworth et al., 1999; Edwards et al., 2000; Fagin et al., 1996; Hannigan et al., 2000), the Philippines (Turnipseed & Turnipseed, 1997), Ireland (Anonymous, 2004), Singapore (Boey, Chan, Ko, Goh, & Lim, 1997), Germany (Schmitz, Neumann, & Oppermann, 2000), Holland (Bakker et al., 1996; Buunk, Ybema, Van Der Zee, Schaufeli, & Gibbons, 2001b), Turkey, (Cam, 2001; Demir, Ulusoy, & Ulusoy, 2003), Australia (Allen et al., 2002; Moore, 2001) and New Zealand (Dewe, 1987, 1989; Finlayson & Gower, 2002; Hall, 2001; Stanton, 1988/99).

The assumption that nurses are prone to job stress and burnout - its most severe form - is grounded in a vast literature on occupational stress demonstrating that nursing is a '>stressful' occupation. The following quote is testimony to the embedded nature of stress in nursing.

ANursing is, by its very nature, an occupation subject to a high degree of stress.

Every day the nurse confronts stark suffering, grief, and death as few other people do.

Many tasks are mundane and unrewarding. Many are, by normal standards, distasteful, even disgusting, others are often degrading; some are simply frightening”

(Hingey, 1984:19).

Nursing is characterised by exposure to a wide range of potentially stressful situations and conditions (Buchan, 1995; Collins, 2000; McAbee, 1991; Santamaria, 1996). Job stressors include factors such as excessive or high workloads (Kelly & Cross, 1985; Motowidlo, Packard, & Manning, 1986), irregular and unsocial hours of work (Kandolin, 1993), physical tiredness (Power & Sharp, 1988), the emotional demands of dealing with sick patients and their families and with patients whose behaviours are difficult (Podrasky & Sexton, 1988), and lack of staff support, uncertainty concerning treatment, conflict with other nurses, supervisors and medical staff, dealing with death and dying, management difficulties, issues involving patient care, concerns about technical knowledge and skills (Bailey, 1980; Benoiel, McCorkle, Georgiadou, Denton, & Spitzer, 1990; Blumenthal, Lavender, & Hewson, 1998; Bourbonnais, Comeau, Vezina, & Dion, 1998; Robinson, Clements, & Land, 2003).

Overall the literature convincingly demonstrates that stress is a long-standing problem for nurses irrespective of nationality, type of nursing training, area or type of clinical or non-clinical work (Aiken et al., 2002b; Allen et al., 2002; Cox & Leiter, 1994). It is difficult to compare the findings of the many reported studies on stress Apart from drawing the conclusion that nursing is a stressful occupation@ (Santamaria, 1996:22). Job stress and its relationship to burnout is further discussed in sections 4.1 and 4.2.

### **3. Nurses= burnout**

The study of burnout had its genesis on the mid seventies when Freudenberger (1974) identified >burnout= as a major problem in human service professionals. He described

burnout as a situation whereby clinical hospital staff including himself (a medical doctor), came to be >inoperative=. Since then there have been in excess of three thousand publications on the topic, and burnout has been recognised as an occupational hazard for a variety of people-centered professions, such as human services, education and health care (Maslach, Schaufeli, & Leiter, 2001). Burnout is frequently studied in populations of nurses for several reasons. These reasons include the fact that nursing is a large health care professional body, it has been linked to a high incidence of burnout (Jones, 1962), the very nature of nursing is based on empathy, compassion and humanisation of medicine, and nurses as professionals are involved with people on an extremely personal level in an environment that is not always conducive to positive consequences (Buunk et al., 2001a).

Burnout has its origins in physical, emotional or psychological demands as well as institutional demands. It has been argued that the basic causes of burnout lie with the disruptive emotional aspects of patient care, such as overly demanding patients, unreasonable patient behaviour, illnesses, (especially those involved in contact and extreme pain and/or certainty of death) that are difficult to treat and which may lead to a strong emotional response from the nurse as well as recognition that there is sometimes denial by care givers to their emotional responses to a patient=s pain (Freudenberger, 1974; Freudenberger, 1975; Maslach et al., 2001; Maslach, 1982; Maslach & Jackson, 1984; Pines, Aronson, & Kafry, 1981). The result seems to be a continuous negative contact between the care giver and the environment in which he or she works. Pines et al. (1981), demonstrated that burnout is significantly correlated with reduced satisfaction with work, life, and oneself as well as with poor physical health (increases in sleep disorders, headaches, loss of appetite, nervousness, backaches and stomach aches). Burnout is also related to hopelessness, tardiness, and an



intention to leave one's job in nursing (Mimura & Griffiths, 2003).

Burnout is a complex subject that has been studied as a sole concept as well as in conjunction with other workplace factors. A plethora of variables and interrelationships has been examined including organisation and work-related factors. Most of the research that has examined causes of burnout has focused on conditions in the job environment and have found that role stressors, such as long hours, are associated with burnout (Cordes & Dougherty, 1993; Handy, 1988; Schaufeli, Bakker, Hoogduin, Schaap, & Kladler, 2001). Nonetheless, the question remains as to why some individuals are burned out while other individuals working in similar environments are not.

The most likely explanation is that causes of burnout are found in both the individual and the environment, but Kahill's (1988) review of the empirical evidence from 1974 B1984 concluded that the influence of individual characteristics on burnout had largely been ignored. Since then significant relationships between burnout and demographic characteristics (e.g. marital status) have been reported (Russell, Altmaier, & Van Velzen, 1997) and attention is now being given to the effects of individual characteristics, personality and burnout (Zellars et al., 2000) but the results are still far from conclusive.

#### **4. The stress-burnout relationship**

Nurses are deemed to be at a higher risk of experiencing burnout than some of the other helping professions because of the implicit relationship of job stress to burnout (Crickmore, 1987; Duquette, Kerouac, Sandhu, & Beaudet, 1994). Numerous studies have been conducted among nurses working in a variety of different clinical practice settings in order to better understand the nature of the implied stress-burnout relationship. These include Critical

Care Units (CCUs) (Boyle, Grap, Younger, & Thornby, 1991), dialysis nurses (Lewis et al., 1992), Intensive Care Units (ICUs) (Crickmore, 1987; Lally & Pearce, 1996), undergraduates (Beck, 1995), student nurses (Admi, 1997), geriatric nursing (Duquette, Kerouac, Sandhu, Ducharme, & Saulnier, 1995), psychiatric nursing (Melchior, Bours, Schmitz, & Wittich, 1997; Sullivan, 1993), nurse tutors (Bamber, 1991), hospice caregivers (Duffy & Jackson, 1996), burns (Steenkamp & van der Merwe, 1998), neonatal nurses (Oehler, Davidson, Starr, & Lee, 1991), midwives (Bakker et al., 1996; Beaver, Sharp, & Cotsonis, 1986), hospice nurses (Payne, 2001), oncology nurses (Escot, Artero, Gandubert, Boulenger, & Ritchie, 2001; Jenkins & Ostchega, 1986), community mental health (Fagin et al., 1996), AIDS/HIV nursing (Bellani et al., 1996; Bennett & Kelaher, 1994). Despite the volume and breadth of this research however, little light has been shed on specific causes and inter-relationships between stress and burnout according to clinical nursing practice setting. Hillhouse and Adler (1997:1782) concluded that "These studies have yielded inconsistent results, with no clear evidence of differences in terms of stress or burnout".

#### **4.1 The implied high stress/high burnout relationship**

The proposition that high stress clinical care settings lead to increased incidence and degree of burnout (high burnout) has also been extensively examined. Much of the early research on nursing stress and burnout focussed on the relative stressfulness of clinical areas that are perceived as >high= stress - such as ICUs, CCUs and hospices - with those that are perceived as >low= stress, i.e., typically non-specialised, clinical environments such as general medical, community health (Bartz & Maloney, 1986; Chiriboga & Bailey, 1986; Foxall, Zimmerman, Standley, & Bene, 1990; Keane, Ducette, & Adler, 1985; Kelly et al., 1985; Maloney, 1982; Van Servellen & Leake, 1993). However, while many studies demonstrate a

strong correlation between high levels of stress in >high= stress work environments and increased incidence and degree of burnout among nurses (Schmitz et al., 2000), others produce evidence showing there is no correlation (Chiriboga et al., 1986).

#### **4.2 Evidence of a high stress/low burnout relationship**

Some studies have even shown that nurses working in high stress, specialised environments (including Mental Health, Forensic Mental Health, Haemophilia Treatment, as well as ICUs & CCUs) are less burned out than their counterparts working in those perceived as >low= stress environments (Buunk et al., 2001b; Edwards et al., 2000). For example Brown et al. (2002:51) found 'Arelatively low rates of burnout as measured by the MBI' in their study of Hemophilia Treatment Centre Nurses, and Chen and McMurray (2001:152) discovered 'A low to moderate levels of total component scores [on the MBI] in all intensive care nurses and on all the three subscales of the assessment instrument'.

Carson et al.'s (1999:131) study of 648 ward-based British nurses and their article entitled 'Burnout in Mental Health Nurses: Much ado about nothing concludes that:

A[t]he single most important finding to emerge from the present study was the relatively low incidence of burnout in the large sample of mental health nurses surveyed. Only 5.7 percent of our total sample could be described as being high burnout."

They account for this finding by explaining that the vast majority of nurses were coping in their changing work environments. Statistically significant differences were found in the low burnout groups' utilisation of coping skills derived from the Cooper Coping Skills Scale; a 28 item Coping Skills measure containing six subscales (Cooper, Sloan, & Williams, 1988).

These included >social support=, >organisation of tasks=, >involvement with work aims=, and >total coping skills=. Their study provides clear evidence that the majority of mental health nurses do not suffer from occupational burnout syndrome (Carson et al., 1999:133). Other research concurs with these findings. For example, Kilfedder et al.'s (2001:383) study of 510 British psychiatric nurses found that only 2.0% of the sample could be categorised as having high burnout overall...they differed significantly from the rest only in terms of males being over-represented." Finch and Krantz (1991) also noted that "[w]ork at Fountain House, as in most psychiatric settings, is stressful. Staff at Fountain House however, show less evidence of burnout associated with occupational stress than would be expected from experience and reports in the literature."

A similar pattern of low burnout for allied >high= stress health professionals also exists. A study of 2400 Dutch Medical specialists conducted by (Visser, Smets, Oort, & de Haes, 2003) found that the respondents were remarkably satisfied with their work, despite high levels of stress with mean burnout scores that were even somewhat below the average for Dutch health care professionals. In studies of anaesthetists (Nyssen, Hansez, Baele, Lamy, & Keyser, 2003) and physical and occupational therapists (Balogun, Titiloye, Balogun, Oyeyemi, & Katz, 2002) the reported median stress level was found to be no higher than in other populations (policemen and office workers), but no explanation is provided for these findings.

### **5. Nurses less burned out relative to other occupational groups**

Research that considers nursing at an occupational level rather than by the relative stressfulness of clinical specialty or nursing type provides evidence of less severe than

expected burnout among nurses relative to other occupational groups.

Five nurse population studies using the MBI and Phase Model of Burnout were compared with other non-nurse population studies that used the same research methodology. The *Phase Model of Burnout* (Golembiewski, Boudreau, Munzenrider, & Luo, 1996) extends the description of the three MBI constructs and proposes an eight-phase model of progressive burnout placing the individual in one of eight phases of burnout from I (least advanced) through to VIII (most advanced). An >advanced=, i.e., a seriously inoperative stage, is determined by adding together the percentage of respondents in Phases VI, VII and VIII (Golembiewski, 1999; Golembiewski, Boudreau, Ben-Chu, & Huaping, 1998; Golembiewski et al., 1996). The nurse studies comprised 1134 New Zealanders and 558 Canadians (Hall et al., 1999), 100 and 30 Israelis (Malach-Pines, 1999a, and 1999b respectively), and 78 North Americans (Lee and Henderson 1996). The non-nurse population studies represented 194 New Zealand production, service and small business employees (Boudreau, 1999), 189 Irish professionals (Coghlan, 1999), 293 Belize workers (Aldinger, 1999), 2771 Malaysian municipal workers (Huang, 1999), and 6692 (in 20 work settings) North American workers (Golembiewski et al., 1998).

Table 1 shows the percentage of respondents in each of the burnout phases and in the >advanced= category.

.....Table 1 about here .....

These studies provide evidence of less severe than expected burnout in nurses as an

occupational group compared to a variety of other occupational groups. They suggest that nurses are somehow managing to avoid, minimise, or at least not to progress to the advanced phase of burnout.

Overall the literature identifies a variety of stress-burnout relationships in nursing. These include low stress/high burnout, high stress/high burnout, low stress/low burnout, and an unexpected high stress/low burnout relationship - given the implied causal relationship between high stress and burnout and reports of increased stress in health care environments. Although definitive conclusions cannot be drawn, the evidence suggests that there is a relationship between job stress and undesirable work related and personal outcomes, particularly burnout. What remains unclear however is the specific aetiology, nature and dynamics of the stress-burnout relationship.

## **6. Theoretical explanations for low burnout**

Two authors theoretically account for low burnout in nurses. One of these, Malach-Pines (2000, 2002, 2004) uses an existential perspective to explain the phenomenon of low burnout in Israeli nurses. Whilst noting that life in Israel is very stressful, and that Israel has gone through five major wars and even during peace times that civilians live with the constant threat of terrorist activity, Malach-Pines (2004:69) proposes that the Aroot cause of burnout lies in people=s need to believe that their lives are meaningful”. She asserts that the greatest sense of existential significance felt by people in the medical profession is because of their daily confrontation with life and death issues and her explanation for low burnout, not only in nurses, but also in teachers and managers, is due the fact Athat Israelis as less burned out, not despite, but because of the constant reminders to the threat to their existence” (Malach-Pines,

2004 :69). Her earlier work (Malach-Pines, 1999a) asserted that the more democratic style of interpersonal relationships, the traditional and clearly defined hierarchical relationships between nurses and physicians, and the larger and stronger support systems that are characteristic of the Israeli people act as buffers against burnout. It is difficult however, to generalise the existential theory to other western settings given the unique Israeli work context.

A substantive and clear link between Kanter's (1977; 1979; 1993) theory of empowerment and lower levels of burnout in nurses was first demonstrated by (Laschinger, 1996). Subsequent studies continue to support the idea that structural and psychological empowerment in the workplace positively affects nurses' perceptions of job strain and work satisfaction, which in turn ameliorate against the effects of chronic job stress and burnout (Laschinger, Finegan, Shamian, & Wilk, 2001b; Laschinger, Finegan, Shamian, & Wilk, 2003; Laschinger, Finegan, Shamian, & Wilk, 2004; Laschinger & Wong, 1999; McBurney, 1997; O'Brien, 1997). This research clearly demonstrates that empowered nurses are more likely to have increased autonomy, decreased job stress, increased job satisfaction, increased commitment, and lower burnout (Kuokkanen, Leino-Kilpi, & Katajisto, 2002, 2003; Laschinger, Finegan, Shamian, & Almost, 2001a; Laschinger et al., 2003; Laschinger & Havens, 1996; Laschinger, Sabiston, & Kutzcher, 1997).

Figure 1 shows the theoretical relationships of concepts in Kanter's (1977, 1993) structural theory of power in organisations (Laschinger, 1996; Laschinger & Almost, 2004; Laschinger et al., 2001b). An overview of this framework is now provided.

.....figure 1 in here .....

### 6.1 Kanter=s structural theory of empowerment

Kanter (1977, 1993) maintains that work environments that provide structural support - including access to information, resources, support, and the opportunity to learn and develop - are empowering. She suggests that empowered employees are more likely to function as team members, participate in decision making, and feel they have control over their work conditions. *Systemic power factors* are located in formal and informal power systems. *Formal power* is derived from formal job characteristics, e.g., the flexibility, adaptability, creativity associated with discretionary decision making, and recognition grounded in the visibility and centrality or job relevance to organisational purposes and goals. *Informal power* is derived from connections inside and outside the organisation. It evolves from an individual=s network of alliances with sponsors, peers, subordinates and cross-functional groups. Access to these empowering structures is facilitated by both formal and informal job characteristics.

The three organisational opportunity structures that influence work effectiveness in organisations are opportunity, power and proportions. The *structure of opportunity* relates to job conditions that provide individuals chances to advance within the organisation and to develop their knowledge and skills. Kanter (1979, 1993) suggests that opportunity is a key influence on employees= work satisfaction and productivity. Whereas individuals in >high opportunity= jobs are usually highly committed to the organisation and they are highly motivated to do well in their careers, those in >low-opportunity= jobs tend to limit their work



aspirations, are less committed to the organisation, and are cautious and resistant to change. The *structure of power* involves three inherent organisational sources of power, i.e., lines of information, lines of support, and lines of supply. To feel empowered, employees need access to work related knowledge and information. This includes technical knowledge and expertise, as well as formal information concerning what is happening in the organisation as a whole. Access to lines of resources or supply means having the ability to obtain materials, money, and rewards necessary to perform the job. Lines of support relate to sources of support that function together in a way to maximise effectiveness, i.e. things like positive feedback from superiors and colleagues.

Powerlessness occurs when individuals do not have access to resources, information, support, and opportunity. Disempowered individuals may feel stuck in their jobs, lacking opportunities for growth and mobility, or be excluded from organisational decision making. They end up being accountable without power, which creates feelings of frustration and failure and may lead to burnout. Empirical research supports the proposition that higher perceived work empowerment is related to low levels of burnout. For instance, Hatcher and Laschinger's (1996) study of 78 nurses working full time in an acute care hospital found significant correlations between overall job empowerment and EE, DP, and PA scores. Low burnout indicated by low EE scores (M=2.39, SD=1.11), very low DP scores (M=1.15, SD=1.00), and high PA scores (M=5.16, SD=.72) was found in nurses who had even a moderate degree of empowerment, and a moderate degree of access to opportunity, information, support, and resources (Laschinger, 1996: 32).

Employees with access to the power and opportunity structures within the organisation are

more likely to be highly motivated and are able to motivate and empower others by sharing the sources of power and empowered individuals have control over conditions that make their actions possible resulting in organisational effectiveness. However, while structural empowerment is useful because it discusses the conditions of the work environment, it does not describe the employee=s responses to these conditions. Laschinger (1996) employs Spreitzer's (1995) theory of psychological empowerment to account for the personal impact of structural conditions on employees.

According to Spreitzer (1995), empowerment is the psychological state that employees must experience for managerial empowerment interventions to be successful. Her research found that managers who felt they had access to strategic information in the organisation and to information on other units= performance felt psychologically empowered thereby demonstrating that structural and psychological empowerment were linked. Higher levels of job-related structural empowerment have been associated with greater psychological empowerment, lower levels of job strain, greater work satisfaction increased organisational commitment among nurses (Laschinger, Finegan et al. 2001) and physical therapists (Miller, Goddard, & Laschinger, 2001). Nurses who are empowered in their work are more likely to be effective. Work effectiveness includes, measures of achievement and successes, respect and co-operation in the work organisation, and indicators of client satisfaction.

## **7. Discussion**

It seems that despite the wealth and scope of literature on occupational stress and burnout, the empirical evidence does not yet provide the nursing profession with a cogent theoretical

framework in fully understanding and explaining the antecedents, consequences, and process involved in job stress and burnout among nurses. While it is clear that job stress results in burnout among some individuals, also apparent - yet not explained by the available empirical evidence - is the fact that others faced with high levels of job stress do not experience burnout. This makes it difficult to generalise research findings about the stress-burnout relationship, other than to acknowledge the co-existence of four different relationships - high stress/high burnout; high stress/low burnout, low stress/high burnout and low stress/ low burnout. Evidence also suggests that low degrees of burnout exist in all kinds of nursing work environments and that nurses relative to other occupational groups nurses are not progressing to the >advanced= or severe form of burnout. In sum, nurses appear to be not as burned out as might have been expected in a stressful profession.

Only two authors theoretically account for low burnout. While Malach-Pines (2004) focuses on the individual in an Israeli context, Kanter's (1977, 1993) theory relates to the work environment and is generalisable to a variety of healthcare settings. It is suggested that understanding Kanter=s theory of structural power and its relationship to burnout is important for the future functioning of the profession of nursing. Kanter states that access to information, resources, support and opportunities to learn and develop are empowering. Empowered workers are effective workers who participate in decision making, feel they have control over their work and are unlikely to burnout.

Reviewing Kanter=s opportunity structures and thinking about their relationship to burnout may also shed some light on the high stress/low burnout phenomenon. Jobs thought to be highly stressful, such as I.C.U., C.C.U., HIV/AIDS care, oncology, because of the nature of

the work, also tend to be high opportunity because of the inherent job characteristics. The corollary of this is that nurses who working in high stress areas plausibly have greater opportunity to develop their knowledge and skills, and to engage in further professional development and learning. The access to opportunities and their associated personal and professional development activities may foster empowerment that counters burnout. In contrast, nurses working in or >low stress= or low opportunity jobs could be more inclined to limit their work aspirations, be less committed to the organisation, cautious and resistant to change, and therefore more likely to be burned out.

Restructuring provides nursing with a chance to change work structures to enhance access to the sources of job related empowerment as described by Kanter.

Therefore it is possible that the process and practice of restructuring hospitals and their management structures may be achieving the goal of increased organisational efficiency and effectiveness through things like improved organisational communication and greater access to information. Feedback from superiors and other colleagues in the organisation, and connections inside and outside the organisation are other important contributors to empowerment. Moore (2001) found that nurses' stress during restructuring was mediated by them viewing restructuring changes as a challenge and by social support and communication by their managers and colleagues. Restructuring may also have played apart in improving workplace relationships with its emphasis on performance management and performance appraisal as a prescriptive requirement of the new managerialist health care environment. Hospitals and other health care organisations might also be investing more in training and development as part of their overall strategic management of performance (Garrett et al., 2001; Mee et al., 2003). Empowerment might therefore be an outcome of

changes to work conditions that are central to recent and ongoing healthcare reform. This could partially explain why, even in an increasingly stressful environment, nurses who have the necessary structural resources to provide high quality care are not as burned out as we might otherwise have expected.

Finally, it is important to note that a low degree burnout represents a positive psychological state and an effective state of well-being. >Wellness= is part of an emerging literature in positive occupational health psychology that represents a shift from the traditional focus on weaknesses and malfunctioning toward understanding human strength and optional functioning at work (Myers, 2000; Seligman & Csikszentmihalyi, 2000). Research-based knowledge about wellness could also be extended and applied to other occupational groups (e.g. firefighters, social workers) at a high risk of burnout. Conceiving of low burnout as wellness makes a contribution to the literature because it focuses on the positive aspects of work. Positive research has the potential to improve the image of nursing and attract a new generation to the profession. Identifying and modifying possible areas of boredom and frustration such as those that might be experienced in low opportunity work environments can help relieve the high costs of turnover by improving nurse retention. The major contribution of such an approach is that it enhances our understanding of how the organisational context or work environment can affect employees' well-being. This knowledge is essential for the future development and well-being of all nurses and the profession of nursing.

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